Contraception

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Editorial

WHO medical eligibility criteria update

For more than 20 years, the World Health Organization's Department of Reproductive Health, in collaboration with its network of international partners, has issued evidence-based guidance on the safety of various contraceptive methods for women and men with particular medical conditions or personal characteristics. This guidance, the *medical eligibility criteria for contraceptive use* or MEC, offers national family planning programs a comprehensive set of recommendations on whether a woman or man is eligible or not to use a particular contraceptive method. The MEC was conceived as a global normative reference for policy makers and program managers to use when developing their national policies and programs, with the overarching goal of removing unnecessary medical barriers to contraception. To this very day, the MEC continues to serve this specific purpose, as well as contribute toward ensuring sexual and reproductive rights.

Recognition of the importance and societal benefits of universal access to high-quality sexual and reproductive health services and investing in family planning, in particular, by the international community continues to receive prominent attention [1]. Reducing unmet need for family planning was included as one of the key indicators for achieving Millennium Development Goal 5 (MDG 5: improving maternal health). Additionally, reducing unmet need was linked with achieving MDG 4 (reducing child mortality) and MDG 6 (combating HIV/AIDS, malaria and other diseases) [2]. A recent analysis shows that achievement of the five Sustainable Development Goal themes of people, planet, prosperity, peace and partnership depends on investments in family planning [3]. Adding to these global frameworks, in 2012 governments, donors, nongovernmental organizations and civil society convened to establish a global movement to reduce unmet need for family planning and reach 120 million new users of contraception by the year 2020. Guidance within the MEC has played, and will continue to do so, an important role in contributing toward all of these goals.

During the years since the publication of the MEC first edition in 1996, the World Health Organization (WHO) produced revisions of the MEC in 2000, 2003 and 2009. With each revision, we added new contraceptive methods and new medical conditions to the guideline to optimize the document's usefulness and respond to the needs of national programs. In several instances, WHO issued interim guidance when important new evidence became available between the revisions. This interim guidance (addressing bone health, postpartum venous thromboembolism risk and HIV acquisition risk) was published separately and then incorporated into the subsequent fully revised MEC guideline.

Most recently, WHO convened a series of Guideline Development Group (GDG) meetings on 14–15 May 2013, 9–12 March 2014 and 24–25 September 2014, to develop the fifth edition of the MEC. The GDG consisted of 68 individuals representing a wide range of specialised areas (i.e., obstetrics & gynecology, pharmacology, endocrinology, epidemiology, demography, cardiology, program management, biostatistics and family medicine). To prepare the fifth edition, WHO adjusted several key aspects of the revision process to be in closer alignment with requirements set forth in the *WHO Handbook for Guideline Development,* authored by the GRC Secretariat.[1] Specifically, these alterations included

- creation of groups with varying roles to undertake the revision;
- convening an additional consultation to define the scope of the revision, giving priority to controversial topics and those for which new evidence had emerged, including topics addressed in interim guidance, clarifying recommendations with a Category 2/3 classification, and drafting questions relating to population, intervention, comparator and outcome (PICO questions) to guide the preparation of systematic reviews; and
- applying the Grading Recommendations, Assessment, Development and Evaluation (GRADE) approach to evidence review and recommendation formulation.[2]

[1] The first edition was published in 2012, the second edition in 2014.

[2] For further information on GRADE, see: www.gradeworkinggroup.org/index.htm.

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For the fifth edition revision, the GDG prioritized the review of the following: (a) six topics identified as important to the field and/or those topics with new evidence that may warrant a change in the existing recommendation; (b) two topics for which interim guidance was issued following the publication of the fourth edition; (c) contraceptive eligibility recommendations for the inclusion of four new contraceptive methods in the fifth edition; and (d) two topics to provide greater clarity for the recommendations in the fourth edition relating to these topics, at the request of the Guidelines Review Committee. In total, 14 topics encompassing over 575 recommendations were reviewed for the fifth edition of the MEC.

As a result of the GDG's efforts, four new contraceptive methods appear in the fifth edition: DMPA-SC, a subcutaneously administered version of DMPA; ulipristal acetate for emergency contraception; Sino-implant (II), a levonorgestrel subdermal implant; and the progesterone-releasing vaginal ring for use among breastfeeding women. In response to advances in HIV care, recommendations are now available for four main classes of antiretroviral medications (ARVs), and within each class, recommendations address individual ARV medications. For emergency contraception, two new conditions were added: obesity and CYP3A4 inducers. Reflecting current clinical practices, the terminology for several conditions has been updated, namely: HIV/AIDS is now termed as either (a) asymptomatic or mild HIV clinical disease (WHO stage 1 or 2) or (b) severe or advanced HIV clinical disease (WHO stage 3 or 4); known hyperlipidemia is now labeled known dyslipidemias without other cardiovascular risk factors; and the condition superficial venous thrombosis is now termed superficial venous disorders, with an updated subcondition, superficial venous thrombosis (replacing superficial thrombophlebitis).

WHO and collaborating colleagues are pleased to publish seven systematic reviews in this issue of *Contraception*. These systematic reviews address topics that have been a great source of concern or confusion. Publication of these papers should provide greater clarity on a woman's eligibility to use progestogen-only contraceptives during breastfeeding; use combined hormonal contraceptives during breastfeeding; use combined hormonal contraceptives if she has superficial venous disease or has known dyslipidemias; use the progesterone-releasing vaginal ring during breastfeeding; use the Sino-Implant (II); or use the subcutaneously administered DMPA injectable.

Given its commitment to ensure that these recommendations remain up-to-date with the published evidence that supports these recommendations, WHO will continue to monitor the emerging relevant evidence as it is identified through the Continuous Identification of Research Evidence (CIRE) system and take action as needed. [4] WHO welcomes comments and suggestions to improve the guideline (hrx-info@who.int).

The full MEC guidance can be found at http://www.who.int/reproductivehealth/publications/family_planning/MEC-5/en/

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